CALIFORNIA PHYSICIANS' SERVICE*

REPORT ON HEARING BEFORE U.S. SENATE SUBCOMMITTEE ON WARTIME HEALTH AND EDUCATION

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San Francisco

ON August 24, 1944, the Secretary of the Board of Trustees of California Physicians' Service received a telegram from the Honorable Claude Pepper, United States Senator from Florida, Chairman of the Subcommittee on Wartime Health and Education of the Committee on Education and Labor, requesting his presence on the morning of September 20th to testify before the Subcommittee concerning the organization and purposes of California Physicians' Service. After consultation with President Ray Lyman Wilbur, a wire was sent, stating that the Secretary would be present, and it was decided further that in order to have the greatest amount of information available to the committee if it so desired, Dr. Larsen, the Executive Medical Director would accompany the Secretary.

The Secretary and Dr. Larsen arrived in Washington on September 17th, and attended hearings before the committee on September 18th, 19th and 20th, and had numerous consultations concerning C.P.S. and its activities with representatives of the Social Security Board, the United States Public Health Service, the Federal Public Housing Authority and the Farm Security Administration.

The members of the Senate Subcommittee on Wartime Health and Education are: Claude Pepper (Florida), chairman, James M. Tunnell (Delaware), Elbert D. Thomas (Utah), Robert M. LaFollette (Wisconsin), Kenneth S. Wherry (Nebraska).

Heard before the committee were:

Monday, September 18th:

1. Dr. R. L. Sensenich, Board of Trustees, American Medical Association
   Dr. Harvey Stone, Committee on Hospitals and Medical Education, American Medical Association
2. Dr. Roger I. Lee, President-Elect, American Medical Association, and Chairman, Joint Committee on Postwar Medical Service
   Prof. Walter W. Palmer, Chairman, Committee on Postwar Medical Service, American College of Physicians
3. Mr. William Green, President, American Federation of Labor (or a personal representative of Mr. Green)
   Mr. Robert Watt, International Representative, American Federation of Labor
4. Dr. Jean Curran, Dean, Long Island College of Medicine, and member of the board, Bingham Associates Fund
   Dr. Samuel Proger, Medical Director, Pratt Diagnostic Hospital, Boston, Massachusetts
5. Dr. C. Rufus Rorem, Director, Hospital Service Plan Commission (Blue Cross Plans)

Tuesday, September 19th:

1. Mr. Philip Murray, President, Congress of Industrial Organizations (or a personal representative of Mr. Murray)
   Mr. George Addes, Secretary-Treasurer, United Automobile Workers, Congress of Industrial Organizations
2. Dr. Victor Heiser, Chief Medical Consultant, National Association of Manufacturers
3. Dr. Leverett D. Bristol, Chairman, Health Advisory Council, U.S. Chamber of Commerce
4. Dr. John P. Peters, Secretary, Committee of Physicians for Improvement of Medical Care
5. Dr. George Stevenson, Medical Director, National Committee for Mental Hygiene
6. Dr. E. I. Robinson, President, National Medical Association

Wednesday, September 20th:

1. Dr. Ernst P. Boas, Chairman, Physicians Forum
2. Dr. John Radford Boling, President, Florida State Medical Society
3. The Honorable Fiorello LaGuardia, Mayor, New York City
4. Dr. Perry Prather, General Practitioner, Hagerstown, Maryland
5. Dr. T. Henshaw Kelly, Secretary, California Physicians' Service
6. Mr. Albee Slade, Congress of Industrial Organizations.

The representatives of C.P.S. were deeply interested in the nature of the material which the committee, with Senator Pepper doing the questioning, was endeavoring to develop, as they had heard various reports as to the purposes of this committee in holding these hearings. It became evident that Senator Pepper feels that the Wagner-Murray-Dingell Bill may have rough sledding, and being himself interested in the development of increased medical service in the United States, is considering the development of a bill which might accomplish this purpose without going as far as national compulsory prepaid medical care.

Perhaps the purpose of this hearing can best be explained by the questions which Senator Pepper asked everyone who testified before his committee:

1. Do you believe that there is sufficient good medical service available to all the people of the United States?

2. Do you agree that the Federal Government should appropriate money which could be matched on an equitable basis by money from states or political subdivisions thereof, to provide and equip hospitals, diagnostic centers, infirmaries or other

* Ed. Note.—For easier reference, the report by Dr. T. Henshaw Kelly is placed in this department of CALIFORNIA AND WESTERN MEDICINE.

necessary medical facilities in areas where they do not now exist, the need therefor to be shown by the states or political subdivisions thereof and approved by such federal authority as might be named in the act?

3. How should these facilities be staffed and operated to the best interests of all concerned?

4. Do you believe that the Federal Government should appropriate funds to be matched as above, which funds could be used to further the development of, or initiate, plans for the furnishing of prepaid medical care in cities, counties or states where they already exist, or where they might be initiated after the plans have been approved by the state authority and the Federal authority named in the act?

5. How do you believe that these funds could best be used to accomplish the above purpose?

The great majority of those appearing before the committee agreed that there must be some effort made to provide prepaid medical service for large groups of people by some means or another. The representatives of the A. F. of L. and the C.I.O. and Mayor LaGuardia plumped flat-footed for the Wagner-Murray-Dingell Bill, while in general the opinions of the others leaned toward the stimulation and extension of voluntary plans in which the matter of subsidy for some of the low income groups might be considered.

Senator Pepper himself, during the course of the hearings, stated that it is his firm determination to see these purposes, described above, carried out, but that as he is a "good States' rights-er," he leans towards methods suggested by his questions rather than to nation-wide compulsion, and that he believes that from the development and operation of numbers of plans, much may be learned about how to formulate a national plan, if that should become necessary.

The answers to the other questions by most of the participants were fairly generally theoretical, and in some cases nebulous, but most of them yearned towards professional control of the medical service to be provided.

It is not presumptuous to say that California Physicians' Service, with five years of operation behind it and its experiences with the Rural Program for the Farm Security Administration and the War Housing Program with the Federal Public Housing Authority, has practical answers for all of Senator Pepper's questions.

Little time was spent by the Secretary in going over the organization and operation of C.P.S., as that had been covered in a long prepared statement filed with the committee, and he devoted most of his time before the committee to the answers to the questions mentioned above.

1. C.P.S., by its very organization, recognized the need for prepayment of medical service by large groups of the population, and in its operations has found the lack of effective medical facilities in considerable areas in California, and has cared for large groups of people from other areas in the country whose physical condition is mute testimony to lack of medical care.

2: Federal funds are undoubtedly necessary in some parts of the United States to provide lacking medical facilities, and in other areas not so poor, will do much to stimulate the provision of such facilities not already provided. Senator Pepper himself laughed, and said that if the Federal Government made half a million dollars available to a State on a 50-50 basis, if the present governor of the State did not get that money, "the next governor would."

3. C.P.S. is already operating with its own staff facilities which were provided by the Federal Government on the War Housing Projects in which C.P.S. operates its medical service program, and this operation of Federally-owned facilities goes on without difficulty or interference by the governmental agencies in the medical service program. This could well serve as a pattern for the operation of much larger facilities in the communities wherever they might be provided.

4. It has already become evident to C.P.S. that the indigent population and the lowest income workers will undoubtedly require funds other than their own for their satisfactory medical care. For the indigents, these funds now are and will be derived from tax money. The funds necessary for the low income workers must also come either from industry, as part of their wage, or from tax money, or both. C.P.S. has noted an increasing participation by employers in the prepayment of their employees' medical care, and it can be argued that the health of a man and his family is part of a reasonable reward for his work. However, it is unquestionable that participation by the Federal Government and states or political subdivisions thereof in the prepayment of care for these groups will hasten the provision and extension of their medical service.

5. Funds made available could be used to assist in the development of plans already existing and operating, if such plans are approved by the designated authorities, both state and Federal, or could be used to initiate the organization and operation of other plans in needy areas, after similar approval. The character of plans would of necessity differ in different areas, and much could be learned from their experience. C.P.S. itself has already learned that medical service plans can be operated for the Federal Government without interference by the Federal agencies in the professional control of the medical service, and there is no doubt that a satisfactory Statewide medical service plan could be operated by C.P.S. for any given group of the population, as an agent of the government, working under agreements along the lines of those existing with the Farm Security Administration, the Federal Public Housing Authorities and the Local Housing Authorities. There has always been considerable, and at times violent, discussion concerning the terms and content of the proposed agreements or contracts with the governmental agencies concerned, such as occurs frequently when private contracts are under consideration, but once the terms have been agreed upon, it has been possible

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thesia problems. Under such emergency conditions intravenous barbiturates may be useful when there is no danger of inhaling blood and when veins are accessible. In some instances endoctracheal anesthesia may be necessary.

Nitrous oxide-oxygen anesthesia gained considerable popularity in the last war, due in large part to the observation that animals anesthetized with gas-oxygen mixtures were more resistant to histamine shock than those anesthetized with ether.

Cyclopropane is a satisfactory anesthetic agent for casualties who have suffered from shock, because it can be administered with high concentrations of oxygen and with minimum toxic effects. The greatest drawback to its use is its high explosibility. As with other gaseous anesthetics, there is difficulty in transportation because of cylinder bulk. *Ethylene* presents no significant advantages over cyclopropane.

Ether is probably the safest of all inhalation anesthetic agents, especially when combined with oxygen. It appears likely that its harmful effects, except for prolonged operative procedures, have been overemphasized.

Spinal anesthesia is ideal for operations on the lower extremities and lower abdomen in patients *in whom the blood volume and blood pressure are not significantly depressed.* It should *never* be used on a patient who is in shock or has recently recovered from shock.

Recent advances in the use of *intravenous anesthetic* agents indicate that they may be suitable for brief anesthesia in patients suffering from traumatic injuries. A number of short-acting barbiturates are available and, if given in small amounts repeatedly, they may be of value under special emergency circumstances. The use of these drugs is, however, not without danger. One should avoid large doses of such agents in casualties in poor condition, since they are capable of causing histotoxic anoxia. It is essential that an attendant be present at all times in order to make sure that an open airway is maintained and that a high concentration of oxygen is supplied in the inspired air. Intravenous agents have the advantages of small bulk and weight, and freedom from fire and explosion hazards.

Local or regional block anesthesia is the best for operations on patients in shock and should be used whenever possible.

From the anesthesia viewpoint, all hospitals treating casualties can function quite satisfactorily with a few relatively simple substances; namely, procaine, and intravenous barbiturates such as pentothal, and oxygen-ether.

(c) *Penetrating Wounds:*

Penetrating wounds require special consideration because improper treatment of them is likely to result in shock. The care of these wounds is covered in another paper of this symposium.

(d) *Postoperative Care:*

The postoperative care of a shocked patient is similar in many respects to his preoperative care and is as important. *After operation, careful observation and treatment of the patient are necessary to prevent recurring shock.*

SUMMARY OF SHOCK TREATMENT

1. Prevent its development.
2. Stop bleeding.
3. Relieve pain.
4. Avoid continued tissue damage by such measures as splinting of fractures, et cetera.
5. Maintain body temperature—prevent chilling—do not overheat.
6. Place in shock position, unless contraindicated.
7. Give sufficient whole blood, plasma, or serum as soon as possible.
8. Administer warm fluids as indicated.
9. Choose an anesthetic agent which will not aggravate the condition.
10. Do necessary surgery as quickly, and with as little tissue damage, as possible, but only after shock has been controlled.
11. Carefully observe the shocked patient postoperatively. Do not let him relapse into shock. Remember that the primary disturbance in shock is diminution in the effective circulating blood volume. Treat it by intravenous administration of blood, plasma, or serum.

384 Post Street.

REFERENCES

1. OCD Publication 2212: The Clincal Recognition and Treatment of Shock. Copies of this publication may be obtained upon request from your local OCD.
2. Foreign Letters, London: J.A.M.A., v. 122, p. 886, July 24, 1943.
3. Moon, V. L.: Shock, Lea & Febiger, 1942.
4. Fox, Chas. L.: Oral Sodium Lactate in the Treatment of Burn Shock. J.A.M.A., v. 124, p. 207, Jan. 22, 1944.

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for C.P.S. to operate its professional program free-handedly. It would seem, therefore, that when, as and if government participates widely in the provision of medical service for the population or parts thereof, C.P.S. and similar organizations could well be used as the instruments to furnish the professional services required under the programs.

At the conclusion of the Secretary's testimony, Senator Pepper stated that C.P.S. will be the object of further study by his committee.

Dr. Larsen and the Secretary left Washington feeling that the attitude of Senator Pepper and his committee is one of deep interest in the extension of medical care and the methods by which it may be accomplished, with due consideration for the rights and customs of the various groups concerned.*

153 Kearny Street (8)

If you have genius, industry will improve it; if you have none, industry will supply its place.—*Sir Joshua Reynolds.*

* Mr. Albee Slade discussed a general health program and California Physicians' Service, but Secretary Kelly and Medical Director Larsen of C.P.S. had to leave before Mr. Slade made his remarks.